VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 3, 2012

Mr. Alexander Smith, Administrator
Robinson House
89 Main Street
Middlebury, VT 05753

Provider #: 551

Dear Mr. Smith:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **March 27, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	551	A. BUILDING _____ B. WING _____	C 03/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBINSON HOUSE	89 MAIN STREET MIDDLEBURY, VT 05753

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
T 001	INITIAL COMMENTS An unannounced on-site complaint investigation was conducted by the Division of Licensing and Protection on 3/7/12, and the investigation was completed after further off-site review on 3/27/12. The following are regulatory findings.	T 001	See attached Plan of Correction	
T 002	IV.A.1 Resident Care and Supervision General The Director shall provide every resident with the *personal* care and supervision appropriate to his/her individual needs. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the Director failed to provide, for one applicable resident, personal care and supervision appropriate to his/her individual needs. (Resident #1) Evidence includes: 1. Per record review on 03/07/12 of the daily progress notes, Resident #1, who was admitted on 12/09/11, had asked for assistance with bathing on 2 occasions. There was no evidence that assistance was given according to the individual need nor that the resident refused assistance. Per a progress note dated 12/10/11 (8 AM-4 PM) the resident "expressed that this was not the ideal place and was hoping for an at home care provider that could assist with daily needs i.e. shower and dressing". Also on 12/10/11 (7 AM-7 PM) the resident stated "asked that some extra help be found to assist [resident] with showers and personal care as [resident] is used to having someone for 2 hours a day to help...[resident] has been requesting assistance to get into bed...but needs someone to lift the	T 002		

pmc

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T 002	Continued From page 1 legs into bed". There was no evidence a plan was put into place and implemented to assist Resident #1 with the required care needs to maintain well-being. Per interview on 03/09/12 at 8:30 AM the Counsel on Aging (COA) Case Manager stated that when Resident #1 was looking for placement, the need for assistance with personal care and transfers was agreed upon on 12/08/11 with the Case Manager of CSAC for Robinson House. Per interview on 03/07/12 at 3:45 PM, the house manager and supervisor confirmed personal care and supervision was not provided according to the individual need.	T 002		
T 086	VI.2.B.2.a. Common Model Program Standards Treatment Components Process--Identification of Problems and Areas of Successful Life Function Sufficient information shall be gathered during the intake process to permit the identification of specific areas of dysfunction such as unemployment, marital discord or economic crisis, as possible collateral elements contributing to the presenting problem of substance abuse or mental illness. This STANDARD is not met as evidenced by: Based on record review and interview, the Residence failed to have sufficient information gathered during the intake process to permit the identification of specific areas of dysfunction for one applicable resident. (Resident #1) Findings include: 1. Per record review on 03/07/12, Resident #1's chart did not contain intake information which	T 086		

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T 086	Continued From page 2 identifies specific area of dysfunction or needs. Resident #1's chart contained old history and physicals dated 2009 & 2010 which were medical in nature and not specific to the area of dysfunction or other contributing problems. The resident was admitted on 12/09/11 from the hospital with only the medication list and was discharged from the residence on 01/03/12. Per interview at 12:20 PM, the House manager stated that the resident was admitted for respite and to stabilize the medication regime, but there was no evidence, by lack of documentation, found to verify the purpose of the admission. Per interview at 3:45 PM, the House Manager and Supervisor confirmed that there was no intake information for this resident. Also see tag T-0087	T 086		
T 087	VI.2.B.2.b. Common Model Program Standards Treatment Components Process--Identification of Problems and Areas of Successful Life Function Sufficient information shall be gathered during the intake process to permit the identification and specific areas of successful life function and achievement. This STANDARD is not met as evidenced by: Based on record review and interview, the residence failed to have sufficient information during the intake process for use for the Identification of Problems and Areas of Successful Life Function to develop a treatment plan for 1 applicable resident. (Resident #1) Findings include:	T 087		

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T 087	Continued From page 3 1. Per record review on 03/07/12, Resident #1's chart did not contain intake information which identifies problems and achievements used as a basis for development of a treatment plan. Resident #1 was admitted on 12/09/11 from the hospital with only the medication list from the hospital noted in the chart. Per interview at 12:20 PM, the House manager stated that the resident was admitted for respite and to stabilize the medication regime, but no evidence through documentation was found to verify the purpose of the admission. Per interview at 3:45 PM, the House Manager confirmed that there was no intake information for this resident. Also see tag T-0086	T 087		
T 088	VI.2.B.2.c. Common Model Program Standards Treatment Components Process--Identification of Problems and Areas of Successful Life Function The identified problems and achievements shall be used as a basis for the development of a treatment plan and goals for each resident. This STANDARD is not met as evidenced by: Based on record review and confirmed by interview, the Residence failed to complete a treatment plan for 1 applicable resident in the sample (Resident #1). Findings include: Per record review on 03/07/12, Resident #1 was admitted to the residence without any identified problem or achievements for the basis of a treatment plan. Per interview at 11:30 AM the House Manager stated that the resident was only for a respite stay until other housing was found and for medication management. The House	T 088		

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T 088	Continued From page 4 Manager confirmed at that time, that any identified problems and achievements used as a basis for the development of a treatment plan and goals was not completed for this resident. Also see T-0089	T 088		
T 089	VI.2.B.3.a. Common Model Program Standards Treatment Components Process-- Treatment plan The treatment plan shall reflect steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. This STANDARD is not met as evidenced by: Based on record review and interview, the residence did not develop a comprehensive treatment plan for one applicable resident (Resident #1) that identified specific steps taken by residence staff to assist the resident's needs. Findings include: 1. Per record review on 03/07/12, Resident #1 had no identified problem areas or specific goals and interventions for the treatment plan (Direction Plan). There was no planned intervention outlined in any documentation presented during the investigation to the nurse surveyor. During interview at 11:30 AM, the House Manager confirmed that a treatment plan, which would identify all necessary care areas and specific staff interventions that might be employed to meet the resident's needs was not completed for this resident. Also see T-0088	T 089		

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T 090	Continued From page 5	T 090		
T 090	VI.2.B.3.b. Common Model Program Standards Treatment Components Process-- Treatment plan The treatment plan shall contain clear and concise statements of at least the short-term goals the resident will be attempting to achieve, along with a realistic time schedule for their fulfillment or reassessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, the residence failed to develop a treatment plan for one applicable resident at the Residence that contains clear and concise statements of at least the short term goals the resident will be attempting to achieve or a time schedule for their fulfillment or reassessment. (Resident #1) Findings include: 1. Per record review on 03/07/11 for Resident #1, there was no treatment plan that identified clear and concise short-term goals nor time frames. Per interview on 03/07/12 at 12:30 PM, the therapist stated the goal was for Resident #1 to stabilize on the medication and perhaps a new living situation. S/he also stated that a team was involved in deciding that the resident should stay at Robinson House, a Therapeutic Care Residence (TCR) but then stated was not aware of the required paperwork for the TCR. Per interview at 3:45 PM the Direct Supervisor confirmed there was no written treatment plan that identified goals or time frame.	T 090		
T 101	VI.2.B.6.a. Common Model Program Standards Treatment Components	T 101		

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T 101	Continued From page 6 Process--Resident Records A residence shall ensure: 1. its responsibility for safeguarding and protecting the resident record against loss, tampering or unauthorized disclosure of information; 2. Content and format of resident records are kept uniform; 3. entries in resident records are signed and dated. This STANDARD is not met as evidenced by: Based upon interview and review of 1 applicable resident record, the residence failed to ensure that the residents records are complete, kept uniformed and are accessible (Resident #1). Findings include: 1. Per record review on 03/07/12 at 10:00 AM for Resident #1, not all available information was found in the clinical record. Resident #1 had progress notes for January 2012 in the computer (EMR) and the hard copy file contained only a signed consent form, medication list and medical information from a recent hospital stay. The staff person was unable to access the progress notes from the December 9 -31, 2011 in the EMR for review. The House Manager was contacted at 11:15 AM to try to access the EMR which then stated that "all the information should be in the hard copy charts by now". The Supervisor was contacted at 11:30 AM but then instructed staff to contact the IT department, which had only access to limited information. The nurse surveyor was then told to travel to the central office to try to have access to the EMR. Two staff stated "there are usually problems with the EMR, especially out here". From 2:00 - 2:30 PM the administrative assistant tried to procure a password for the	T 101		

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T 101	Continued From page 7 nurse surveyor. The Direct Supervisor and House manger confirmed at 3:45 PM that the content and format of resident records are not kept uniformed and was not readily accessible. Records for residents must be kept at the site of residence and all staff involved with the care of that resident must be able to access the information at any time.	T 101		
T 102	VI.2.B.6.b. Common Model Program Standards Treatment Components Process--Resident Records Resident records shall include the following: 1. intake assessment summary 2. identification of problems and areas of successful life function 3. data from other agencies 4. treatment plans and goals 5. regular progress notes 6. supervisory and review conclusions 7. aftercare plan and discharge summary 8. appropriate medical information 9. client information release form This STANDARD is not met as evidenced by: Based on record review and interview, the Residence failed to ensure that all treatment components are included in the record of 1 applicable resident. (Resident #1) Findings include: 1. Per review on 03/07/12, Resident #1's record (admitted 12/09/11) was incomplete. During record review the resident's record contained old History and Physicals for 2009 & 2010, recent hospital stay discharge summary, medication list and a client release form. There was no identification of problems and areas of successful	T 102		

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T 102	Continued From page 8 life function, treatment plans and goals, supervisory and review conclusions or aftercare plan and discharge summary. Per interview at 3:45 PM the House Manager and Direct Supervisor confirmed that the resident's record was incomplete.	T 102		
T 106	VI.2.B.8.c. Common Model Program Standards Treatment Components Process--Discharge and Aftercare A summary of the resident's stay at the facility shall be added to the resident record within one week of his/her leaving. This shall include reason for leaving, areas in which progress, no progress or regression was observed, and medication at the time of leaving. This STANDARD is not met as evidenced by: Based on record review and interview, there was no summary note after Resident #1's discharge. Findings include: 1. Per review on 03/07/12 Resident #1 was discharged on 01/03/12 . The progress note of that date states "'S/he left with (Case Manager of CSAC)at 10:00 AM, signed out all the [resident] medications and all of the [resident] belongings were packed and sent along." The note did not have a reason for leaving, areas in which progress, no progress or regression was observed, or the list of medications at the time of leaving. There was a monthly summary from the therapist (CRT) however, no summary from the discharge from the residence. This was confirmed during interview at 3:45 PM with the Direct Supervisor and House Manager.	T 106		

Department of Disabilities, Aging, and Independent Living
Division of Licensing and Protection

Response to Survey done on ~~3/7/2012~~
3/29/2012

Plans of Correction for Robinson House

T002: Resident Care and Supervision

Action Taken: Assessment will be done and a direct care plan for each consumer and steps to achieve this. Documentation will be kept in file and consumer daily progress note with activities. See attached assessment.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T086: Common Model Program Standards

Action Taken: Complete intake will be completed for every prospective consumer going to Robinson House with all pertinent information including current discharge from hospital and medication if applicable. Recommended treatment will be in file as well as goals.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T087: Common Model Program Standards

Action Taken: An Intake will be completed with directives and a residential goal sheet. See attached.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T088: Common Model Program Standard

Action taken: A residential direct care plan will be completed on each consumer prior to entry into the program. All prospective consumers will fill out intake and sign all pertinent forms for care.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Date corrective actions implemented: April 30, 2012

T089: Common Model Program Standard

Action taken: A Needs Assessment will be completed with directives. See attached.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Date implemented: April 30, 2012

T090: Common Model Program Standard

Action Taken: Needs Assessment and Residential Goal Sheet will be completed.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Date implemented: April 30, 2012

T101: Common Model Program Standards

Action Taken: All residential progress notes will be available in hard copy in each consumer's file.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T102: Common Model Program Standards

Action Taken: An Intake including Needs Assessment will be completed. Hospital discharge plans and current medications list if applicable will be on file. Appropriate consumer information release forms if needed will also be on file.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T106: Common Model Program Standards

Action Taken: See attached discharge plan.

Measures and Monitoring: Will be done on weekly basis by house manager and assistant site manager.

Dates corrective actions implemented: April 30, 2012

T002 → T106 POCs accepted 5/2/12 SEmmonsRN / PMcateerRN